Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MILLENNIUM CHIROPRACTIC
615 N O'CONNOR RD SUITE 12
IRVING TX 75061

DWC Claim #: 08275184
Injured Employee: JOSEFINA RODRIGUEZ
Date of Injury: 06/03/08
Employer Name: BOSTON MARKET CORP
Insurance Carrier #: 002587-340521-WC01

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-10-2760-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: **"…**Attached you will find multiple Explanations of Review, wherein Gallagher-Bassett is denying payment for Pre-Authorized services performed, on the basis of:
52 – The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service. … [IW] received approval to change treating doctors by the DWC-Dallas Field Office Manager. The [IW's] treating doctor at that time, [doctor] had released her to find a new treating doctor, as he was unable to help her any further, and she was still reporting a great deal of pain. After this doctor change had been approved, Gallagher-Bassett filed a PLN-11, disputing the change of doctor…"

Amount in Dispute: $23,104.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: **"**Despite the Requestor's diatribe, the Respondent is not liable to reimburse the Requestor per the Texas Workers' Compensation Act and its associated rules. As stated in Texas Labor Code 408.021(c), reimbursement is only owed for 'health care approved or recommended by the employee's treating doctor." Because the Division determined in its Decision and Order the Requestor could not serve as treating doctor, he is simply not entitled to reimbursement. Respondent's denial of reimbursement is proper and authorized as shown herein."

Response Submitted by: Downs & Stanford, P.C.; 2001 Bryan Street, Suite 4000; Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2009	98940 97140-59-GP 97110-GP 97112-59-GP G0283 97012	$364.97	$36.00
May 6-7, 13-14, 2009	97140-59	$ 311.52	$311.48
June 15, 17, 24, 2009	97140-59	$233.64	$233.61
July 1, 2009	97140-59	$77.88	$77.87
June 3 and 8, 2009	98940	$72.00	$72.00
June 3, 2009	G0283	$17.32	$0.00
June 12, 2009 June 23, 2009 July 22, 2009	98940 97140-59-GP 97110-GP 97112-59-GP G0283-GP 97012-GP	$1,094.91	$978.03
July 20, 2009	98941 97140-59-GP 97110-GP 97112-59-GP G0283 97012	$377.99	$340.85
August 26-28, 31, 2009	97799-CP	$2960.00	$2960.00
September 1, 14-18, 21-25, 2009	97799-CP	$8800.00	$8800.00
October 5, 7-9, 15-16, 19, 22-23, 26, 2009	97799-CP	$8000.00	$8000.00
August 26, 2009 September 22, 2009 October 29, 2009	97750-FC	$779.40	$779.34
October 6, 2009	99080-73	$15.00	$15.00
		Total Due:	$22,604.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

4. Texas Labor Code §413.031(c) states, “In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules…”
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers’ compensation professional medical services provided on or after March 1, 2008.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of specific codes, services and programs provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Multiple Explanations of benefits dated May 22, 2009 through January 14, 2010

   - 219 – based on extent of injury
   - 59 – processed based on multiple or concurrent procedure rules
   - B7 – this provider was not certified/eligible to be paid for this procedure/service on this date
   - 19 – (197) precertification/authorization/notification absent
   - 52 - the referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed
   - Additional note: CCH OFFICER FOUND THE EMPLOYEE DID NOT HAVE THE APPROVAL TO CHANGE PHYSICIANS TO THIS DOCTOR

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Have the extent of injury issues been resolved?
3. Is the requestor eligible to perform the services billed?
4. Did the requestor obtain preauthorization for physical therapy sessions?
5. Did the requestor obtain preauthorization for a chronic pain management program (CPM)?
6. Is the requestor entitled to reimbursement for other professional services?

Findings

1. 28 Texas Administrative Code §133.305 (a)(4) states, “Medical Fee Dispute—A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee’s compensable injury. The dispute is resolved by the Division of Workers’ Compensation (Division) pursuant to Division rules, including §133.307 of this subchapter (relating to MDR of Fee Disputes).” 28 Texas Administrative Code §133.307 (a) (3) states that the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules.
2. A contested case hearing (CCH) was held on September 8, 2009 and concluded that claimant’s compensable injury of June 3, 2008 (lumbar sprain/strain) extends to include injury to the cervical spine but does not extend to include a 2-3 mm disc protrusion at L5-S1; annular tears at L3-L4, L4-L5, or L5-S1; or lumbar radiculopathy. The Division concludes that there are no unresolved issues of extent pertinent to the services in dispute. Therefore, this dispute will be reviewed per to 28 Texas Administrative Code §133.307.
3. The requestor is a doctor of chiropractor and therefore is eligible to perform the services billed.
4. The division reviewed the preauthorization approval letters for physical therapy:
   - Approval #5760765 dated May 7, 2009 with start and end dates of 5/1/09 to 7/31/09: Chiropractic 3xWk x 2Wks lumbar & cervical – 6 visits with a mutual agreement that stated: “treatment trial of 6 visits chiropractic 98940 lumbar, cervical.”
   - Approval #6273366 dated June 3, 2009 with start and end dates of 5/29/09 to 7/29/09: Code 98941 2-3x/wk x 4wks-total of 12 session and chiropractic codes 97140-59, 97110, 97112; 2-3x/wk x 2-3wks-total of 6 sessions.
   - Approval (no number provided) dated July 21, 2009 with a start and end date of 7/16/09 to 9/16/09 for 2 visits only: Codes 98941, 97140, 97110, 97112 at 2xWk x 1Wk
   - The requestor billed CPT codes 98940, 97140-59, 97110, 97112-59, G0283, and 97012 on May 4, 2009 and CPT code 98940 on June 3, and 8, 2009. Preauthorization approval #5760765 included a mutual agreement statement of, “a treatment trial of 6 visits chiropractic 98940 lumbar, cervical.” CPT codes 97140-59, 97110, 97112-59, G0283, and 97012 were not on the approval letter. Recommend reimbursement for CPT code 98940 only on these three dates of service as follows:
   - CPT code 98940: $53.68÷36.0666 x $24.72 = $36.79. Requestor seeks $36.00, this amount recommended.

- CPT code 97140-59 billed on May 6, 7, 13, 14, 2009; June 15, 17, 24, 2009; and July 1, 2009 was denied with reason code -59 (multiple or concurrent procedure rule). The respondent did not provide sufficient detail in the explanation of benefits to explain this denial reason; therefore, this denial reason is not supported. CCI edits were applied in accordance with 28 Texas Administrative Code §134.203(b) (1) which states: "for coding, billing, reporting and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policy, including its coding; billing, correct coding initiatives (CCI) edits, modifiers; …and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." CCI edits indicate that procedure code 98940 and component code 97140 are unbundled. The use of an appropriate modifier may be allowed. The requestor billed with an appropriate modifier; therefore, recommend reimbursement as follows:
- CPT code 97140-59: $53.68÷36.0666 x $26.16 x 2 units = $77.87 x 8 days = $622.96
- The requestor billed CPT code G0283 on June 3, 2009. This procedure requires preauthorization but was not listed on any of the preauthorization request letters. No reimbursement recommended.
- The requestor billed CPT codes 98940, 97140-59, 97110, 97112-59, G0283, and 97012 on June 12, 23, 2009 and July 22, 2009. Preauthorization approval #6273366 and #5760765 was obtained for these services with the exception of CPT codes G0283 and 97012. Recommend reimbursement as follows:
- CPT code 98940: $53.68÷36.0666 x $24.72 = $36.79. Requestor seeks $36.00 x 3 days, this amount recommended = $108.00
- CPT code 97140-59: $53.68÷36.0666 x $26.16 x 2 units = $77.87 x 3 days = $233.61
- CPT code 97110: $53.68÷36.0666 x $28.37 x 4units = $168.90 x 3 days = $506.70
- CPT code 97112-59: $53.68÷36.0666 x $29.05 = $43.24 x 3 days = $129.72
- The requestor billed CPT codes 98941, 97140-59, 97110, 97112-59, G0283, and 97012 on July 20, 2009. These services (except G0283 and 97012) were preauthorized on July 21, 2009. Recommend reimbursement as follows:
- CPT code 98941: $53.68÷36.0666 x $34.16 = $50.84.
- CPT code 97140-59: $53.68÷36.0666 x $26.16 x 2 units = $77.87
- CPT code 97110: $53.68÷36.0666 x $28.37 x 4units = $168.90
- CPT code 97112-59: $53.68÷36.0666 x $29.05 = $43.24

5. The division reviewed the preauthorization approval letters for a chronic pain management program.
    - Approval #7817853 dated September 8, 2009 with a start and end date of 9/2/09 to 11/02/09: Pain management 5xWk x 2Wks 8 hours a day – 10 visits.
    - Approval #7829012 dated September 29, 2009 with a start and end date of 9/24/09 to 11/24/09: Pain management 5xWk x 2Wks 8 hours a day – 10 visits.
    - CPT code 97799-CP billed on dates of service August 26, 2009 through October 26, 2009 was preauthorized. The respondent reimbursed one day of the CPM program, August 25, 2009 (not in dispute). The carrier's denial reason is not supported. Services are payable in accordance with 28 Texas Administrative Code §134.204 (h) (5) (A) (B) which states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. Recommend reimbursement as follows:
    - DOS August 26, 2009: $100/hr x 8 hrs/day = $800.00 minus carrier payment of $240.00 = $560.00
    - DOS August 27 to October 26, 2009: $100/hr x 8 hrs/day = $800.00 x 24 days = $19,200.00
6. The requestor billed three Functional Capacity Evaluations (FCEs) with CPT code 97750-FC on August 26, September 22, and October 29, 2009. According to 28 Texas Administrative Code §134.204(g), "…a maximum of three FCEs for each compensable injury shall be billed and reimbursed… FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test. Documentation is required…" The documentation submitted is reviewed. The requestor billed 1.5 hours (6 units) on each date of service. Recommend reimbursement as follows:
    - 53.68÷36.0666 x $29.09 = 43.30 x 6 units = $259.78 x 3 days = $779.34
7. The requestor billed 99080-73 on October 6, 2009. Per 28 Texas Administrative Code §129.5 (b), the doctor shall file a Work Status Report in the form and manner prescribed by the Division. Recommend reimbursement of $15.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the services in dispute as outlined above. As a result, the amount ordered is $22,604.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $22,604.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	DEE Z TORRES	May 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.